Date_____

Patient Information

Patient's Name: _____ Male__ Female__ Birthdate____/____/_____
Last First MI

SS#: _____Preferred Name: _____ Status: Minor __Single__ Married__ Divorced __ Widowed__

Mailing Address: _____
City State Zip

Cell#: _____ Work#: _____ Home Phone#: _____

Email: _____ Referred by: _____

Employer: _____Occupation: _____ Do you have Children: yes__ No__ How Many?: __

Spouse's Name: _____ Emergency Contact : _____ Phone#_____ Relationship _____

Responsible Party Information

Name: _____ Birthdate: ____/____/____ Relationship to Patient: _____

Address: _____ Phone#: _____ SS#: _____
Is patient currently a patient at our office? Yes __ No __ Payment method: ___ Cash ___ Check ___ Credit Card ___ Care Credit # _____

Insurance Information

Primary Dental Insurance

Insured's Name: _____ Birthdate: ____/____/____ SS#: _____ID#_____

Ins. Name: _____Phone#: _____ Address: _____

Group#: _____ Plan: _____ Relationship to Patient: _____ Employer: _____

Secondary Dental Ins.

Insured's Name: _____ Birthdate: ____/____/____ SS#: _____ ID#_____ Group # _____

Ins. Name: _____ Phone#: _____ Address: _____

Relationship to Patient: _____ Insured's Employer: _____

Authorization for Release

I authorize the dentist to release any information, including the diagnosis, x-rays and records of treatment.
I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than actual bill for services. If for some reason your insurance sends payment directly to you (the patient), you are responsible for paying the balance.

Dental History

Reason for today's visit: _____ Are you in Pain: _____
Name of previous dentist: _____ Date of your last Exam: _____
Do you require **pre-medication**? Yes____ No____ Pharmacy: _____#_____

Please indicate any of the following problems:

Yes No Discomfort, clicking or popping in jaw?
Yes No Sensitive tooth, teeth or gums?
Yes No Red, swollen or bleeding gums?
Yes No Are your teeth sensitive to hot or cold?

Yes No Have you ever had any head, neck or jaw injuries?
Yes No Do you clench or grind your teeth?
Yes No Have you prolonged bleeding after extractions?
Yes No Do you wear dentures/partials? Yes No Date of placement_____
Yes No Do you have frequent headaches?
Yes No Have you had any Orthodontic treatment?
Yes No Do you have any sores in or near your mouth?
What would you change about your smile? _____

Medical History

Do you have or have you had any of the following?

Yes	**No** AIDs/HIV	**Yes**	**No** Allergies	**Yes**	**No** Alzheimer's Disease
Yes	**No** Anemia	**Yes**	**No** Arthritis/Grout.	**Yes**	**No** Artificial Heart Valve
Yes	**No** Asthma	**Yes**	**No** Bleeding Problems	**Yes**	**No** Blood Disease
Yes	**No** Cancer if yes what type: _____			**Yes**	**No** Chemotherapy
Yes	**No** Congenital Heart Disorder	**Yes**	**No** Diabetes	**Yes**	**No** Drug Addition
Yes	**No** Emphysema	**Yes**	**No** Epilepsy / Seizures	**Yes**	**No** Fainting Spells/Dizziness
Yes	**No** Frequent Headaches	**Yes**	**No** Glaucoma	**Yes**	**No** Heart Disease
Yes	**No** Heat Attack / Failure	**Yes**	**No** Heart Murmur	**Yes**	**No** Heart Pacemaker
Yes	**No** Hepatitis	**Yes**	**No** High/Low Blood Pressure	**Yes**	**No** Kidney Problems
Yes	**No** Liver Disease	**Yes**	**No** Lung Disease	**Yes**	**No** Mitral Valve Prolapse
Yes	**No** Osteoporosis	**Yes**	**No** Psychiatric Care	**Yes**	**No** Radiation Therapy
Yes	**No** Rheumatic Fever	**Yes**	**No** Rheumatoid Arthritis	**Yes**	**No** Scarlet Fever
Yes	**No** Sinus Trouble	**Yes**	**No** Shingles	**Yes**	**No** Stomach Problems
Yes	**No** Stroke	**Yes**	**No** Thyroid Problems/Disease	**Yes**	**No** Tuberculosis
Yes	**No** Tumors/Growths	**Yes**	**No** Ulcers	**Yes**	**No** Venereal Disease
Yes	**No** Do you smoke	**Yes**	**No** Are you Pregnant.	**Yes**	**No** Are you Nursing

Yes No Have you ever taken Phen-fen Other: _____

Are you allergic to or have any reactions to the following?

___Local Anesthetics ___Latex ___Penicillin ___Amoxicillin ___Tetracycline ___Aspirin ___Acrylic ___Codeine ___Sulfa Drugs
___Barbiturates ___Sedatives ___Iodine ___Mercury ___Nickel ___Other: _____

Have you been hospitalized Explain: _____?

Please list all medications you are currently taking:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Financial Policy

Our policy requires payment in full for all services rendered at the time of visit, and any **estimated portion not covered by dental insurance**, unless other arrangements have been made. If account is not paid within 90 days of date of service and no financial arrangements have been made, you will be responsible for legal fees, collection fees, and interest charges.

Cancellation Policy

I acknowledge the fact there is a charge for any missed appointments, unless cancelled 24 hours in advance.

Authorization for Treatment

I authorize the office and Treating Dentist to perform treatment as needed.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

X_____ _____ _____

Signature of patient (or parent if a minor) Date Signature of Doctor